Seizure Care Plan

The seizure care plan defines all members of the team, communication guidelines (how, when, and how often), and all information necessary to support a child who may experience seizures while in child care.

Name of Child: _____ Date: _____

Facility Name: _____

Description of seizure condition/disorder: _____

_____

Describe what the child's seizures look like: (1) what part of the body is affected? (2) How long do the seizure episodes usually last?

_____

_____

Describe any know "triggers" (behaviors and/or symptoms) **for seizure activity**: _____

_____

Detail the frequency and duration of child's typical seizure activity: _____

Has the child been treated in the emergency room due to their seizures? _____ How many times? _____

Has the child stayed overnight in the hospital due to their seizures? _____ How many times? _____

Team Member Names and Titles (parents of the child are to be included)

Care Coordinator (responsible for developing and administering the Seizure Care Plan): _____

_____

_____

ⓘ *If training is necessary, then ALL team members will be trained.*

Planned strategies to support the child's needs and safety issues when the child has a seizure:

(e.g., diapering/toileting, outdoor play, nap/sleeping, etc) _____

_____

_____

❑ Individualized Family Service Plan **(IFSP)** attached. ❑ Individualized Education Plan **(IEP)** attached.

PROBLEM	TREATMENT	EXPECTED RESPONSE
At risk for injury due to uncontrolled seizure activity.	If a seizure occurs, staff will remove objects from the area and place a folded towel/clothing beneath the child's head. Protective helmet is worn as prescribed.	Injuries related to seizure activity will be prevented.
At risk for aspiration of respiratory secretions or vomitus during seizure activity.	If a seizure occurs, staff will roll the child onto his/her side.	Child will not aspirate during seizure activity.
Self-esteem disturbance related to occurrence of seizure or use of protective helmet.	Provide many opportunities for success. Praise achievements and accomplishments. Provide opportunities for child to express feelings about seizures and any activity restrictions. Reassure the other children in the group that the child will be OK if a seizure occurs.	The child will successfully adapt to requirements of living with a seizure disorder. The child will demonstrate a positive attitude toward learning activities. Other children will feel safe.
Parent and child may not be aware of possible triggers.	Staff will document the occurrence of any seizure activity on attached *Seizure Activity Log*.	Parents, staff and the child will learn to identify triggers and how to avoid them.
Child may be very sleepy, but not unresponsive after a seizure occurs.	Staff will make sure that the child is responsive after a seizure, then will allow the child to sleep/rest after the seizure.	The child may safely sleep/rest, if needed, after seizure occurs.

Communication

What is the team's communication goal and how will it be achieved (e.g., notes, communication log, phone calls, meetings, etc.): _____

_____

How often will team communication occur: ❑ **Daily** ❑ **Weekly** ❑ **Monthly** ❑ **Bi-monthly**

Date and time specifics: _____

Other Professionals Involved **Telephone**

Health Care Provider (MD, NP, etc.): _____ _____

Occupational Therapist: _____ _____

Physical Therapist: _____ _____

Neurology Specialist: _____ _____

Other: _____ _____

Specific Medical Information

❖ Medical documentation provided & attached: ❑ Yes ❑ No

❑ **Information Exchange Form** completed by Health Care Provider on-file.

Any known allergies to food and/or medications: _____

❖ Medication to be administered: ❑ Yes ❑ No

❑ **Medication Administration Form** completed by Health Care Provider and parents is on file (including: type of medications, method, amount, time schedule, potential side effects, etc.)

Special Staff Training Needs

Type (be specific): _____

Training done by: _____ Date of Training: _____

Additional Information (include any unusual episodes/behavior changes that might arise while in care and how the situation should be handled)

_____

_____

_____

Support Program the Child is Involved With Outside of Child Care

Name of program: _____

Address and telephone: _____

Contact person: _____

Emergency Procedures

❑ *Special emergency and/or medical procedure required.* Emergency instructions: _____

_____

❖ Call 911 if: ❑ Seizure lasts longer then ____ minutes. ❑ Child is unresponsive after seizure.

❑ Other: _____

Emergency contact: _____ Telephone: _____

Follow-up: Updates/Revisions

This *Seizure Care Plan* will be updated/revised whenever medications or child's health status changes, or at least every 12 months as a result of the collective input from team members.

Date for revision and team meeting: _____

SEIZURE ACTIVITY LOG

NOTE: This should be accompanied by a *Seizure Care Plan* established and on-file for this child.

Name of Child: _____ Room: _____

DATE	TIME	CIRCUMSTANCES PRECEEDING (activity participating in)	DESCRIBE SEIZURE*	LENGTH OF SEIZURE	ACTIONS TAKEN BY STAFF	CHILD'S BEHAVIOR AFTER SEIZURE	STAFF INITIALS

***What To Look For and Note Above:**

- *How did the seizure start? Did the seizure start in just one part of the body and then spread, or did it involve the whole body from the beginning?*
- *Was there smacking or licking of the lips? Eyelid fluttering? Picking or fumbling movements of the hands?*
- *Was the child able to respond to any outside stimulus* (for example, name called, gently shaking shoulder)*? Was the response normal/confused/no response?*
- *Were there stiff and/or jerking movements?*
- *Was the jaw clenched or the tongue bitten?*
- *Was there any color change or breathing problem?*
- *How long did the actual seizure last?*